State Partnerships to Improve the Quality and Availability of Medical Homes to Vulnerable Participants

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Every Child Deserves a Medical Home….

American Academy of Pediatrics

- "A medical home combines place, process and people—
  - The central place where primary care is provided
  - The process and scope of care in that place, and
  - The team of people delivering and coordinating care"

(www.medicalhomeimprovement.org)

Definition of Medical Home

- Care that is:
  - Accessible
  - Family-centered
  - Comprehensive
  - Continuous
  - Coordinated
  - Compassionate
  - Culturally-effective

NCQA:
Physician Practice Connections/PCMH

1. Access & Communication
2. Patient Tracking & Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting & Improvement
9. Advanced Electronic Communication

Medical Home Joint Principles

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks of a medical home
- Enhanced access to care
- Payment appropriately recognizes the added value

Integrated Health *System*

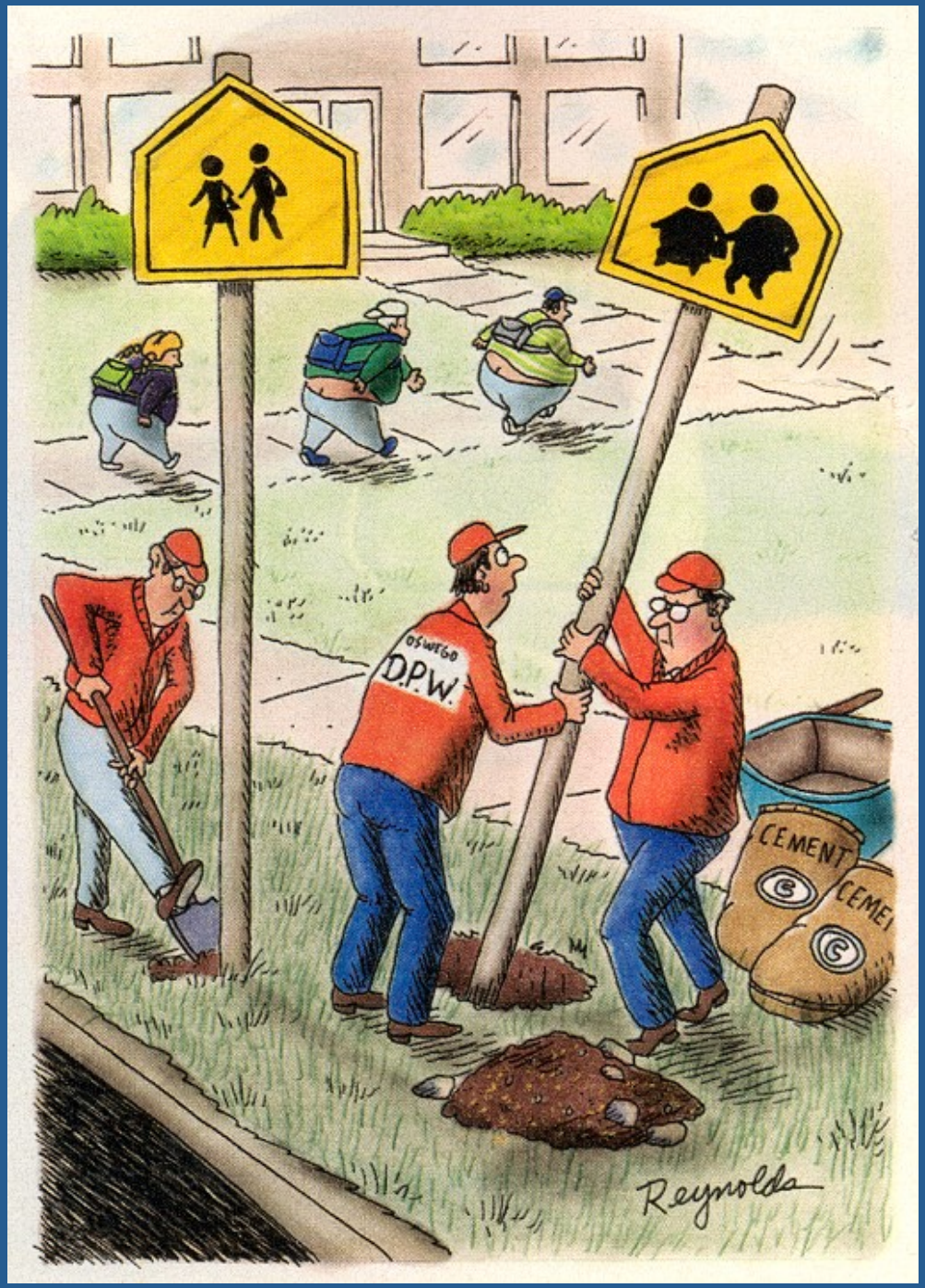
- Patients and Families
- Primary Care Physicians
- **Specialists and subspecialists**
- Hospitals and Healthcare Facilities
- **Public Health**
- **Community**

The Existing Child Health Service System

- Fragmented service delivery
  - Different sectors (health, public health, population health, civic)
  - Different funding streams
  - Different cultures
- Lack of co-ordination
- Narrow programmatic criteria for eligibility
- Variable understanding of child health issues
- Local community generally has limited accountability or responsibility

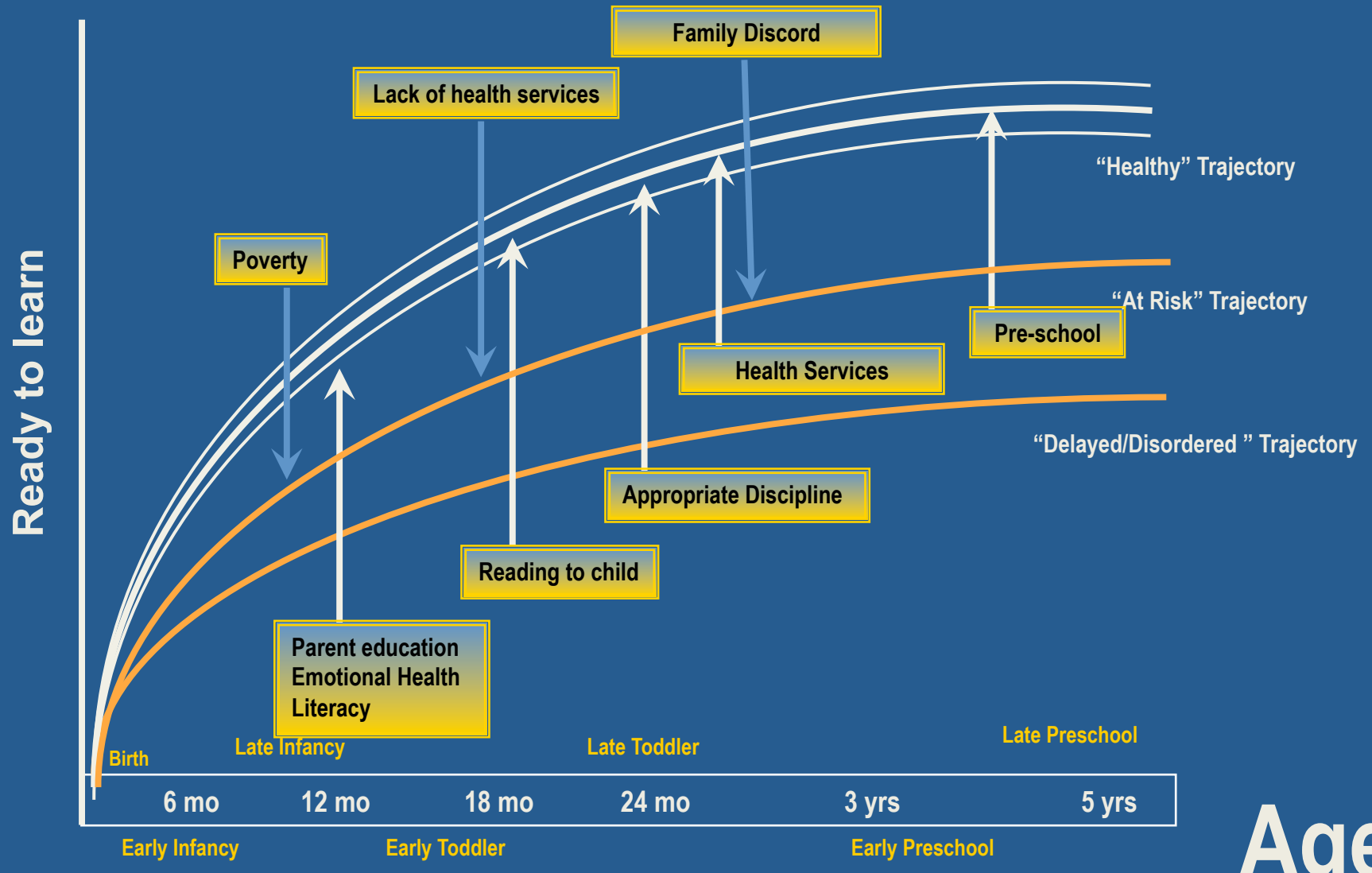
Child Health System: Past to Present

- Steady Progress in Childhood Morbidity for traditional medical conditions
  - Many indicators show improvement
    - Mortality, morbidity, trends improving
- Increasing Rates of chronic conditions, especially mental health, developmental and behavioral conditions, & Obesity
- Increasing disparities

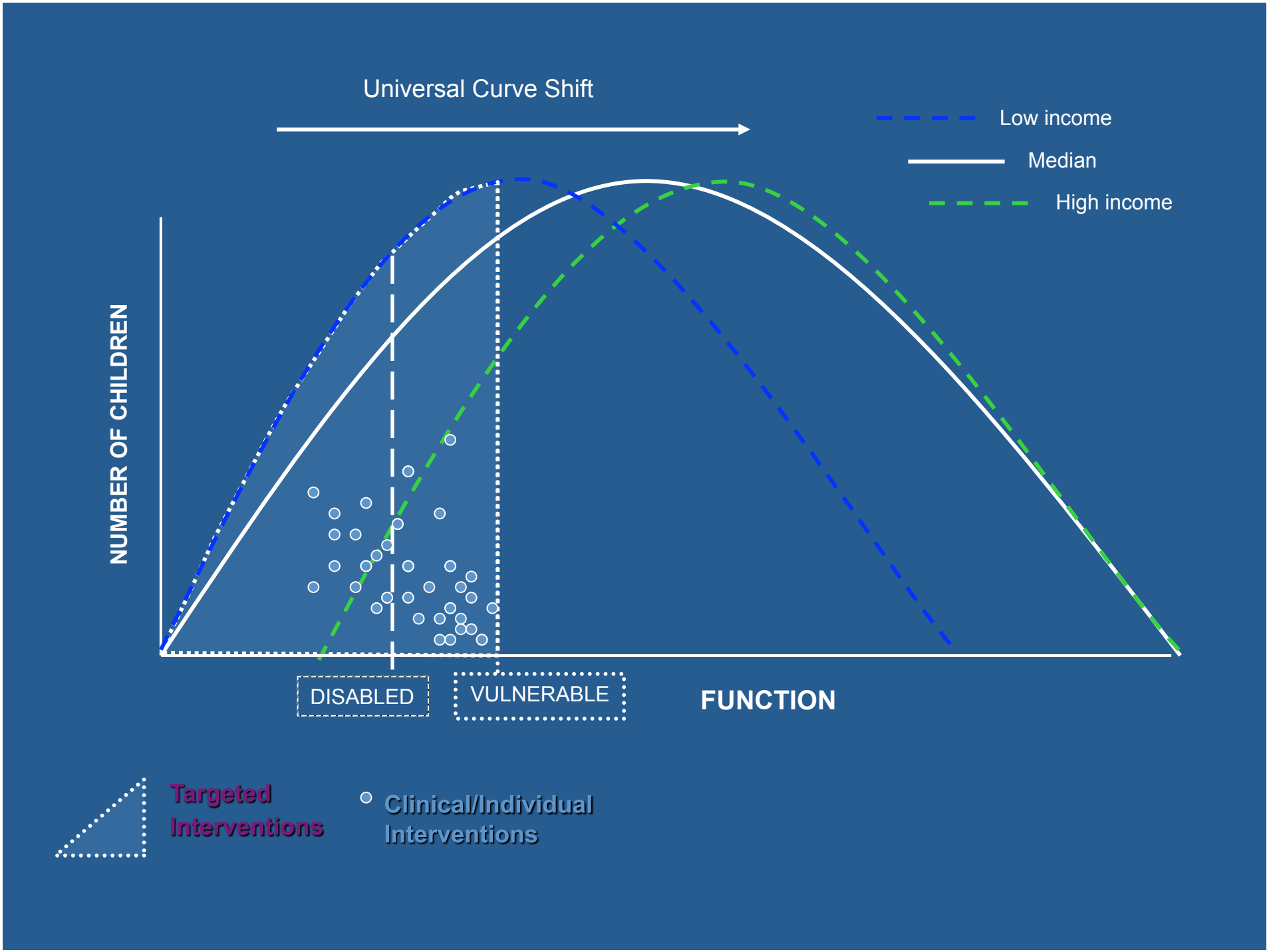

OSWEGO
D.P.W.
CEMENT
Reynolds

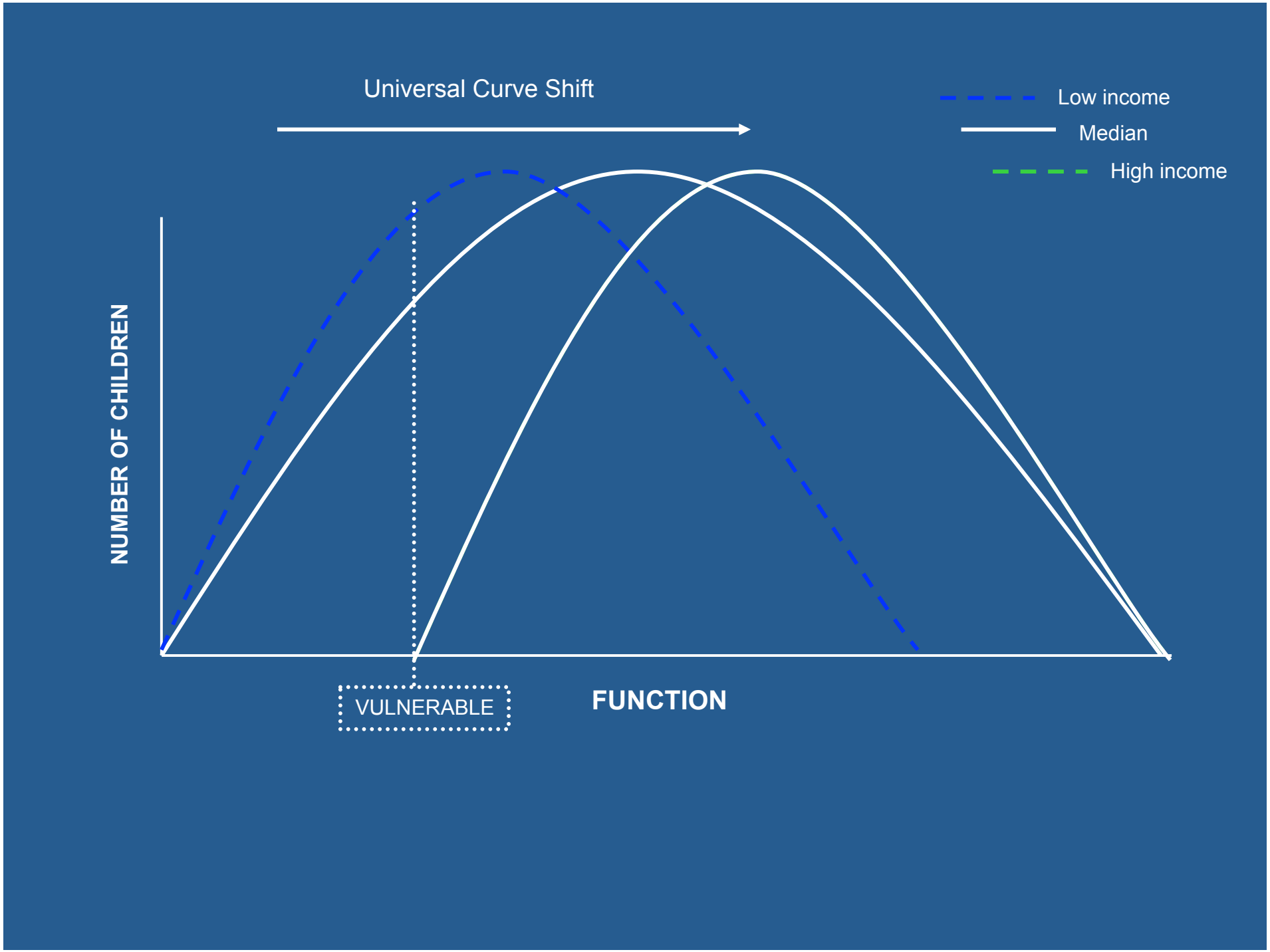
Strategies to Improve
Health Development Trajectories

Back to Overall Model



Graphic Concept Adapted form Neal Halfon , UCLA


Universal Curve Shift
Low income
Median
High income
NUMBER OF CHILDREN
DISABLED
VULNERABLE
FUNCTION
Targeted Interventions
Clinical/Individual Interventions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Virginia Partnership

- Virginia Chapter AAP
- Virginia Department of Medical Assistance Services
- Virginia Community Health Centers
- Carilion Clinic

Virginia Partnership

- Application to the National Academy for State Health Policy project, *Building Medical Homes in State Medicaid and CHIP Programs*

National Academy for State Health Policy

- Virginia one of eight states selected
- Leadership session, October 2009
- Opportunity for TA and mentorship from another state

Virginia's Medical Home Pilot

- Define Project Scope
- Define and Recognize Medical Homes
- Explore
  - Supports for Practice Change
  - Payment Policy (Pennsylvania TA)
- Measure Progess
  - Define outcome measures (access, quality, cost)

Virginia DMAS

- Project Lead
- Convened meetings with other partners
- Collects outcomes of project
  - Access to Care
  - Quality of Care
  - Cost of Care

Focus on Southwestern VA

- Underserved communities
- No Medicaid managed care presence
- Two different health systems
  - Virginia Community Health Centers
  - Carilion Clinic

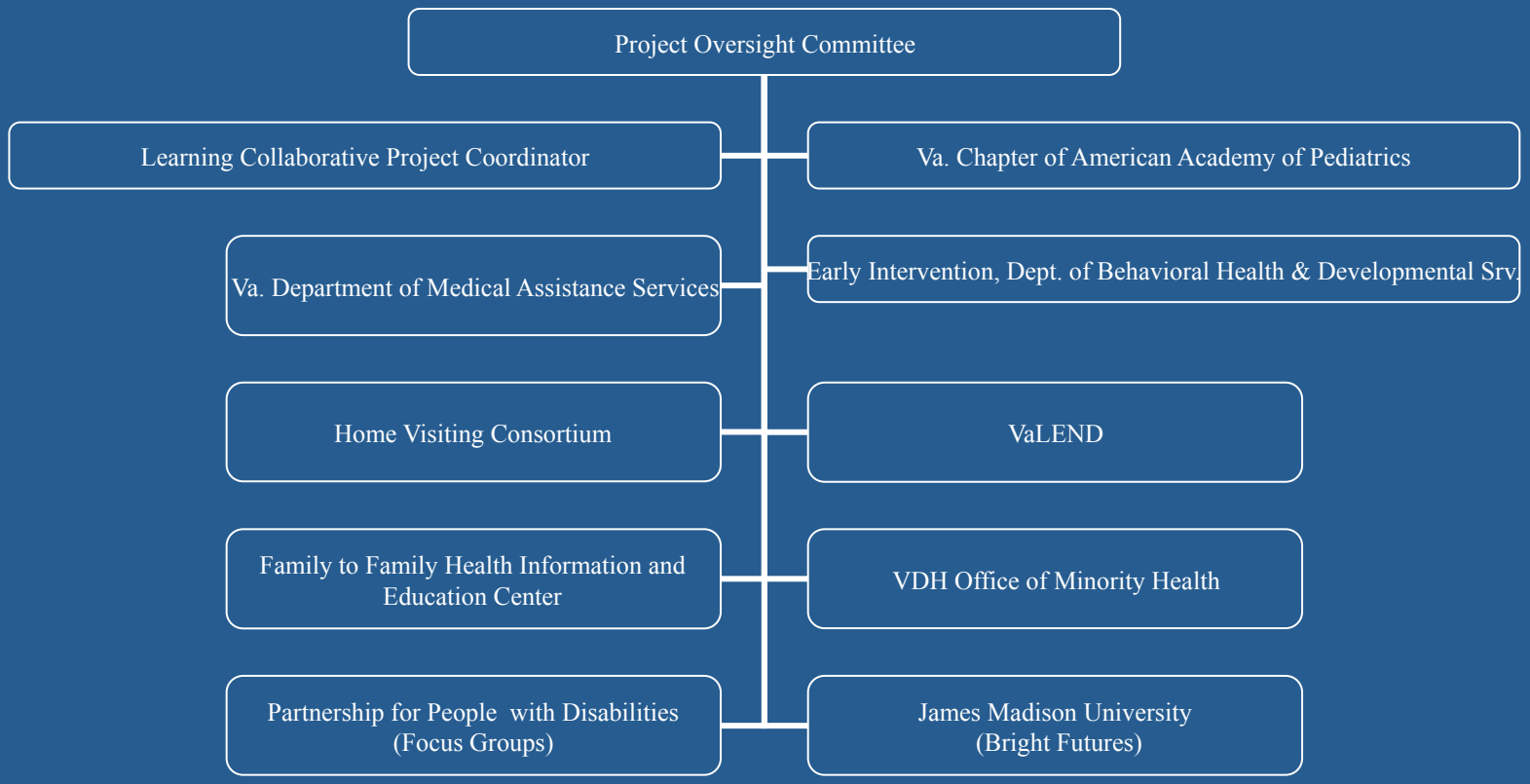
Virginia Community Health Centers

- Several in Southwestern Virginia
- Connected by Electronic Health Record
- Ongoing Quality Improvement and Disease Management Program
- FQHC Funding

Virginia AAP

- Partnership with Title V VDH on Virginia Systems Improvement Plan
- Statewide Quality Improvement project on Developmental Screening in the Medical Home
- Partnerships with Families

Virginia Children and Youth with Special Health Care Needs Systems Improvement Project



Carilion Clinic

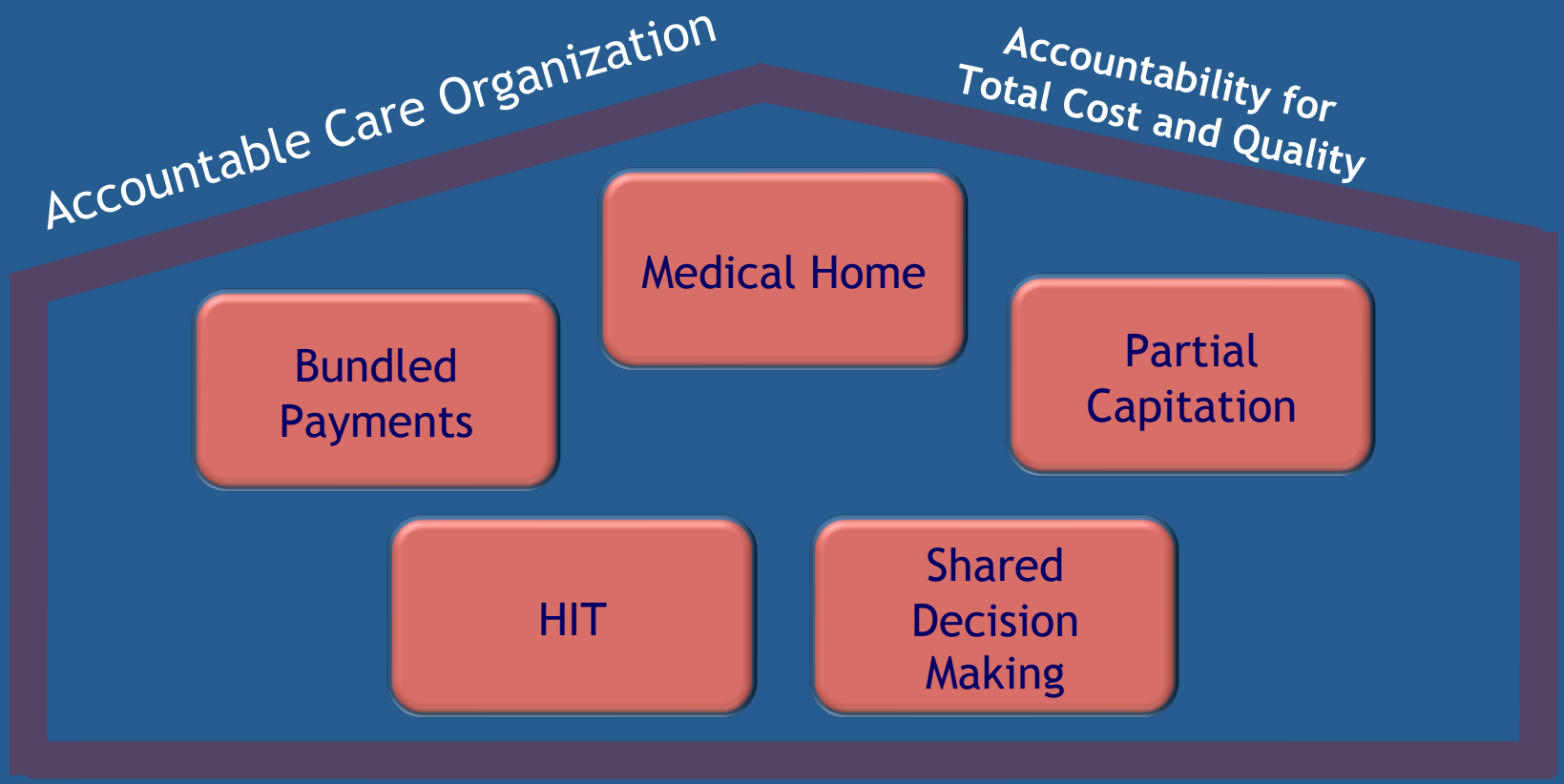
- Medical Home Pilots in Family Medicine and Pediatrics
  - First Practice in the Commonwealth to achieve Level III PCMH/NCQA
- Accountable Care Organization Funding Model
- Working with Brookings Institute and local payors for Access, Quality, and Cost outcomes

Three components of ACO infrastructure

- Local Accountability for Cost, Quality, and Capacity
- Shared Savings
- Performance Measurement

ENGELBERG CENTER for Health Care Reform at BROOKINGS

The ACO is the overarching structure within which other reforms can thrive



ENGELBERG CENTER for Health Care Reform at BROOKINGS

Next Steps

- Measurement of Access, Quality, Cost
  - Community Health Clinics
  - Carilion Clinic
- Learning Collaborative
  - Will a better connection with community care partners increase access and quality?
- What are the emerging models that encourage Medical Home as a model for care of all vulnerable individuals?